



**Department
of Health**

**Office of
Mental Health**

**Office of Alcoholism and
Substance Abuse Services**

**Office of Children
and Family Services**

Health Homes Serving Children CANS-NY and Billing Guidance

June 29, 2016

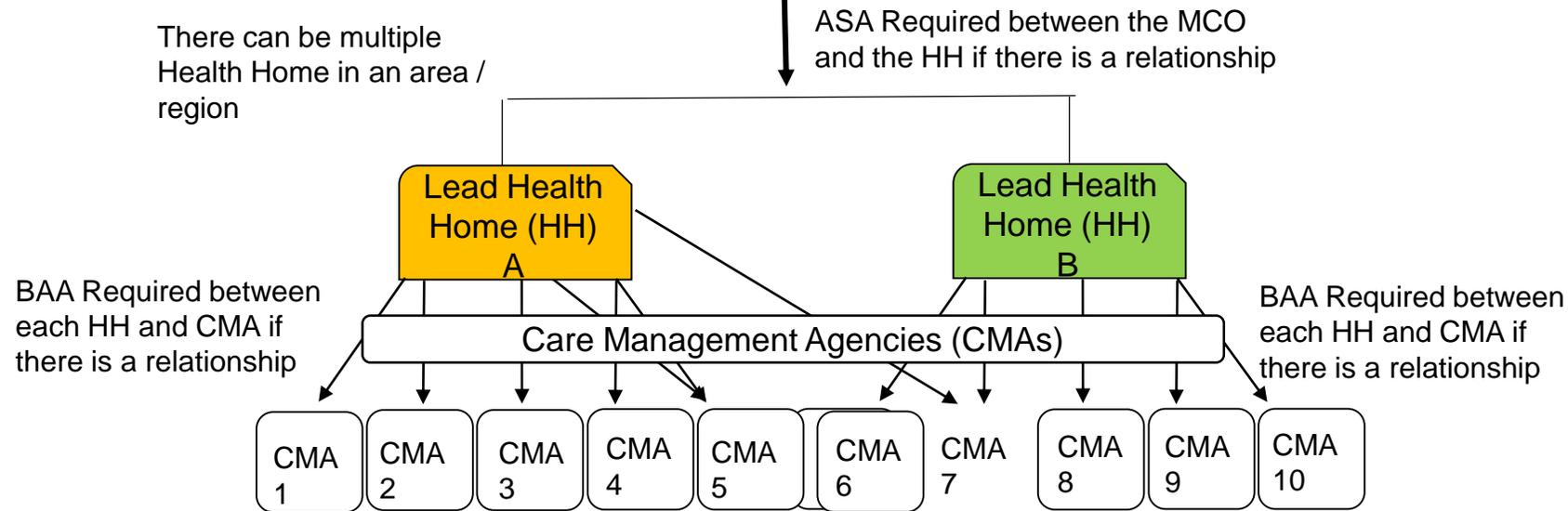
Key Health Home Players and Relationships

Managed Care Organization (MCO)



Key

ASA – Administrative Service Agreement
BAA - Business Associate Agreement
CMA – Care Management Agency
HH – Health Home



The CMA can have a relationship with multiple Health Homes and would need a BAA with each



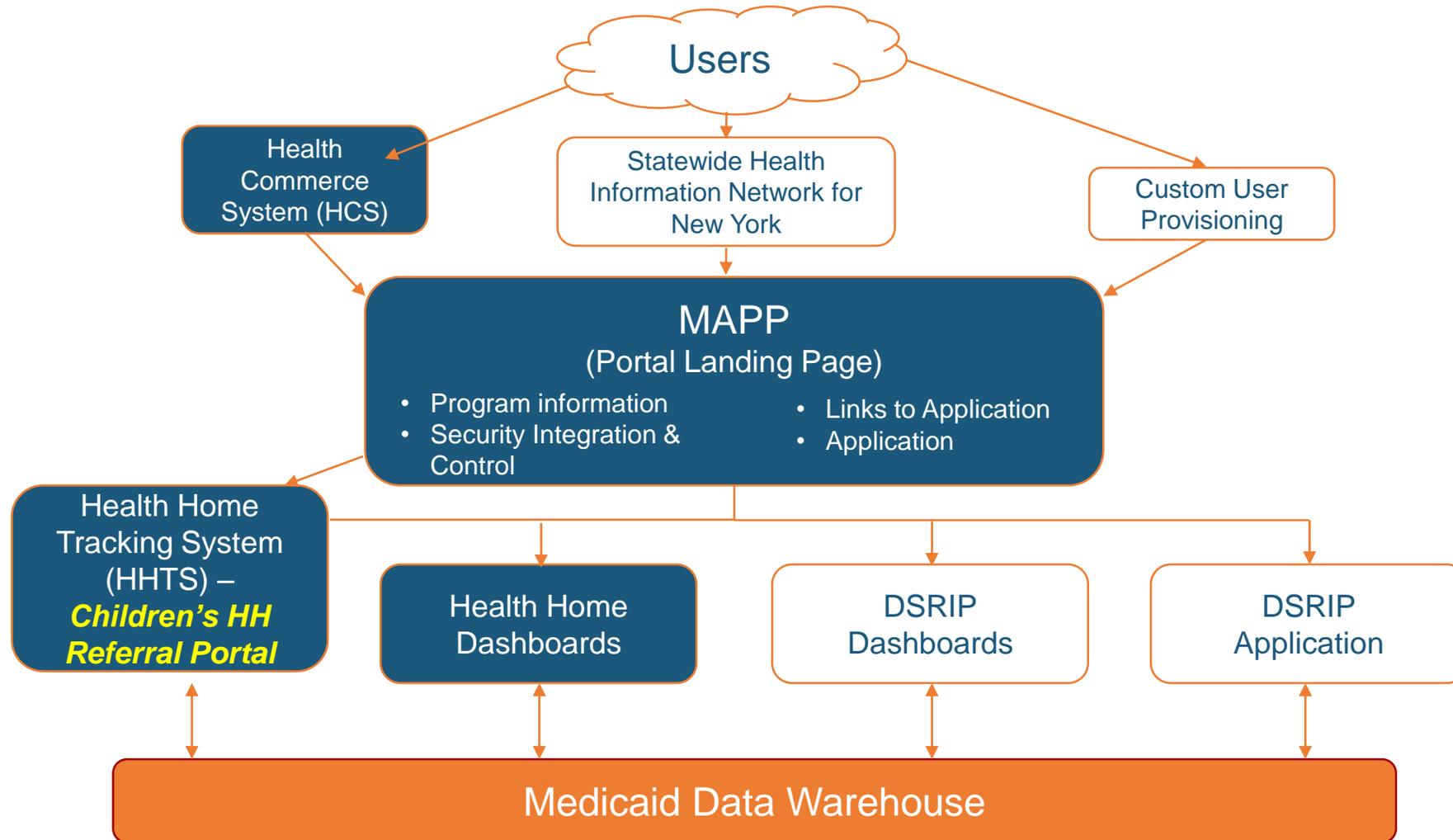
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Medicaid Analytics Performance Portal (MAPP)



Referrals and Enrollment

- Unlike the process for enrolling adults in Health Homes, which is a mix of Assignment List identified members and referrals from the community, Children will be primarily enrolled in Health Home through referrals
- All Children will be manually entered in the MAPP HHTS through referrals entered in the Referral Portal by LGU's, LDSS', Health Homes, Care Managers and Managed Care Plans
(Referral Portal Training Webinar will be provided on July13th)
- A **referral** cannot be made without consent from the member (self-consent may apply) – see consent forms) or parent/guardian/legally authorized representative – information is entered in the Referral Portal and verbal consent can be obtained for purpose of making such referrals
- A member is **enrolled** when a consent forms have been signed.
 - Consent for enrollment 5200 – Must be signed for Health Home enrollment for Children
 - CANS-NY Consent – Must be signed to complete a CANS-NY within the UAS

Children's Health Home Rates

- Effective October 1, 2016, the SPA authorizes the following Children's Health Home Rates for the period October 1, 2016 to September 30, 2018
- An algorithm applied to the CANS-NY tool determines if the rate that may be billed is High, Medium or Low – the algorithm will be calculated in the UAS and billing information will flow from UAS to MAPP

Per Member Per Month HH Care Management Rates for Children under 21 (non-Legacy Providers)		
Acuity (CANS Algorithm)	Upstate	Downstate
High	\$750	\$799
Medium	450	479
Low	225	240
Outreach	135	135
Assessment	185	185



Payment Flow for Health Home Payments

- HH members that are enrolled in Managed Care Plan – (The vast majority of children are enrolled in Managed Care Plans)
 - The Plan will use billing data from MAPP HHTS to submit a claim to Emedny (The Electronic Medicaid system of New York)
 - The Plan will remit funds to the lead Health Home and the lead Health Home will remit funds to the care management agency
- HH Members that are in Fee-for-Service (i.e., NOT enrolled in a plan, includes Foster Care children that will not transition to Managed care until July 2017 NYC/LI and January 2018 ROS, and other children not enrolled in Managed Care Plan)
 - The lead Health Home will use billing data from MAPP HHTS to submit a claim to Emedny
 - The lead Health Home will remit funds to the care management agency
- Billing data is entered into the MAPP HHTS. Some Health Homes request care managers to input billing data in their HH's non-MAPP HHTS system and then directly upload billing and other information on behalf of the care management agency to the MAPP HHTS versus the CMA directly inputting information MAPP HHTS
- These payment flows apply to the Health Home Per Member Per Month (PMPM) fee, the Health Home Outreach PMPM fee, and the one-time CANS-NY Assessment fee
- Managed Care Plans are required to remit payments to Lead Health Homes within 14 days of payment from the State and are required to bill the State no less frequently than once every 14 days
- With launch of MAPP and concerns around payment flow, lead Health Homes will be required to certify they can remit funds to care management agencies ***within 15 days from receipt of funds from the Plans or the State***

Dates of Service on Claims

- The date of service on Health Home claims submitted to NYS Medicaid by the Plan or Lead Health Home, as applicable, must be the 1st of the month for the services that were provided during that month.
 - For example, if services are provided on October 11, 2016, the date of service on the Health Home claim will be October 1, 2016.
- **Every month**, a HH/CMA must complete billable Health Home services and the required monthly MAPP Billing Questionnaire
 - There is a monthly MAPP Billing Questionnaire for adult and children

General Billing Rules

- Only Health Homes that have been designated to serve children may bill Children's High, Medium and Low Health Homes' rates, determined by the CANS-NY acuity algorithm for members under 21
 - The Monthly Children's Billing Questionnaire in MAPP is required to be completed
- Any Health Homes that serves a member that is 21 and over must bill the Adult High, Medium and Low rates (will take effect on September 1, 2016)
 - There is a Monthly Adult High, Medium, Low Assessment (similar to Billing Questionnaire) in MAPP
- Health Homes must have care managers and a network of providers, or documented arrangements with other providers, that ensure it can comprehensively meet the member's needs and provide it access to services it is eligible for (e.g., HARP members who required CMHAs, and adults HCBS services)



Scenario 1:

Billing Rules for Designated Health Homes Serving Children and Adults that *do not have separate MMIS ID#'s*

- Health Homes that have been designated to serve both children and adults who **do not** have separate MMIS ID numbers will be prompted **upon enrollment only** in MAPP of members under 21 with the following question: “Indicate whether the child will be served by the children’s designated HH network, or with consent, the adult designated HH network”
- It is the general expectation that members under 21 would be served by care managers and providers in the children’s designated network
 - The question accommodates potential, exceptional circumstances that must be document that the member’s needs are comprehensively met, has access to services that the member is eligible for and obtained appropriate consent (The State will provide further guidance)
 - For example: children under 21 that may self consent such as a 17 year old and married; that have an existing relationship with a care manager that serves adults; their needs can be better met by the adult network
- Members for which the Health Home indicates “children’s designated HH network” will bill Children’s High, Medium, and Low rates and will be prompted with the Children’s Billing Questionnaire
- Members for which the Health Home indicates “adult designated HH network” will bill Adult High, Medium and Low rates and will be prompted Adult High, Medium, Low Assessment

Scenario 1a:

Billing Rules for Designated Health Homes Serving Children and Adults *with Separate MMIS ID #'s*

- Health Homes that have been designated to serve both children and adults who **do** have separate MMIS ID numbers will not be prompted with a network serving question at enrollment
- Children's High, Medium and Low rates will be billed for members under 21 for members associated with their children MMIS ID#
- Adult High, Medium and Low rates will be billed for members 21 and over for members associated with their adult MMIS ID#



Scenario 2:

Billing Rules for Health Homes **Only** Designated to Serve Children

- Health Homes that have been designated to serve only children will **not be** prompted with network serving question at enrollment
- Members enrolled in children's only designated Health Home will be primarily under 21
- Children's High, Medium and Low rates will be billed for members under 21
- Children's High, Medium and Low rates cannot be billed for members that turn 21 – Adult High, Medium and Low rates must be billed
- Members, under prescribed circumstances with choice, consent and documentation, that are over 21 may be enrolled in a Health Home Designated Only to Serve Children – State will provide additional detailed guidance



Scenario 3:

Billing Rules for Health Homes **Only** Designated to Serve Adults

- Health Homes that have been designated to serve only adults will **not be** prompted with network serving question at enrollment
- Members enrolled in adult only designated Health Home will be primarily 21 and over
- Adult High, Medium and Low rates will be billed for members 21 and over
- Children's High, Medium and Low rates cannot be billed for members under 21 – Adult High, Medium and Low rates must be billed
- Members, under prescribed circumstances with choice, consent and documentation, that are under 21 may be enrolled in a Health Home Designated to Serve Adults only – State will provide additional detailed guidance



Children who are **Now Enrolled** in Health Home Prior to Implementation of Children's Health Home Program

- Children who are currently enrolled in Health Homes that, at their initial designation were not authorized to serve children may continue to serve those children
- Care management that remains unchanged – continuity of care that is in the best interests of the member and agreed to by the member and parent/guardian and documented in care plan– Adult High, Medium and Low rates should continue to be billed
- Otherwise, billing rules outlined in the prior scenarios would apply
- State will provide further guidance consistent with that provided in the Health Home Designation Application Process to such Health Homes



Monthly Children's Billing Questionnaire

In order to bill for a billable Health Home service, **every month**, Health Homes are required to complete a "Children's Billing Questionnaire" in MAPP for **Health Home enrolled members**

1. What is the member's primary diagnosis? (not required, pre-populated from prior month "free text" stakeholder request)
2. What is/are the member's chronic condition(s) that determined the member's eligibility for the HH program? (multi-select box):
 - This question is only asked for the first month an enrollment segment is billed
3. Has the child been in Foster Care at any time this month? (yes/no/unknown)

AND

4. Was a core HH service provided this month? (yes/no)
 - This question is asked only for children when the CANS-NY acuity algorithm is low or outreach is being billed

OR

5. Were two HH services provided, one of which must be a face-to-face encounter with the child?
 - This question is asked only for children when the CANS-NY acuity algorithm is medium or high

CANS-NY Assessments

- The CANS-NY must be completed every 6 months from the first day of the month it was completed
- A fee is paid for the initial CANS-NY only
- The CANS-NY will not be pre-populated with previous results
- A one-time assessment fee (\$185) per enrollment **into a children's designated Health Home** may be billed upon *completion of the CANS-NY*
 - *The State is developing practice and billing rules for children in foster care who have had the CANS-NY (the identical tool required to be completed for members enrolled in Health Home) completed within the last 6 months*
- Once the child is enrolled in a Health Home, low acuity is billed for the child until the month in which the CANS-NY is completed and the acuity algorithm determines the appropriate rate (high, medium or low)
- Health Homes will be expected to meet best practice standards by completing the CANS-NY 30 days from the date of enrollment.
- If the CANS-NY is not completed by the end of the second month of enrollment, the Health Home/Plan will no longer be able to bill for any service until the month in which the CANS-NY is completed.



Enrollment Scenario and Billing CANS-NY Acuity

- If Joey is **enrolled** on April 14th (with appropriate consent signed), and the CANS-NY is not completed in the month of April, the HH/Plan can bill low acuity as long as the child/family is actively engaged
- If Joey does not receive a completed CANS-NY in the month of May, the HH/Plan can bill low acuity as long as the child/family is actively engaged*, i.e., one of the 5 core services has been provided.
- If Joey receives a completed CANS-NY in the month of June and the child is determined medium acuity, the HH/Plan will be able to bill medium for the month of June and the one-time assessment fee of \$185.
 - *There will be future guidance regarding children in foster care who have had the CANS-NY (the same tool completed for Health Homes) completed within the last 6 months and billing*
- If Joey does not receive a completed CANS-NY in the month of June, the HH/Plan will not be able to bill for the month of June
- The HH/Plan cannot bill the third month from enrollment without a completed CANS-NY



Billing for a CANS-NY Reassessment

If Joey's last completed CANS-NY was on May 27th, the CANS-NY reassessment would be due in the month of October

- If Joey does not receive a completed CANS-NY in the month of October, the HH/Plan can bill the previous acuity as long as the child/family is actively engaged* and one of the 5 core services has been provided
 - If Joey receives a completed CANS-NY in the month of November and the child is determined high acuity, the HH/Plan can bill high acuity for the month of November as long as the child/family is actively engaged and one of the 5 core services has been provided
 - If Joey did not receive a completed CANS-NY in the month of November, the HH/Plan cannot bill for the month of November
 - The HH/Plan cannot bill for the second month for reassessment without a completed CANS-NY
- ❖ *Reminder: The date of service on Health Home claim must be the 1st of the month for the services that were provided during that month.*



CANS-NY Reassessments, Reasons for Early Reassessments

- Significant events can necessitate a CANS-NY be completed earlier than the six month interval requires, i.e., an Early Reassessment
- Reasons an early CANS-NY reassessment should be completed are:
 1. Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
 2. Service plan or treatment goals were achieved
 3. Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
 4. Child has been seriously injured or in a serious accident
 5. Child's (primary or identified) caregiver is different than on the previous CANS-NY
 6. Significant change in caregiver's capacity/situation
 7. Court request
- Health Homes will be expected to meet best practice standards by completing the Early Reassessment CANS-NY 30 days from the date of the **Documented** significant event selected above.
- There is no fee paid for re-assessments



Health Home 5 Core Billable Services

Health Home Billable Services that will be identified on the Children's Billing Questionnaire and **MUST** be documented in the member's records and care plan, when appropriate (refer to appendix for more information)

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives; and
5. Referral to community and social support services if relevant



Examples of Billable Services Provided Under Each Health Home Core Service (See Appendix/website for more details)

1. Comprehensive Care Management

- A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

2. Care Coordination and Health Promotion

- The Health Home provider is accountable for engaging and retaining Health Home members in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.



Examples of Billable Services Provided Under Each Health Home Core Service (See Appendix/website for more details)

3. Comprehensive Transitional Care

- The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

4. Patient and Family Support

- Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

5. Referral to Community Supports

- The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

Outreach and Engagement

- The outreach fee is a flat fee of \$135 PMPM (outreach may be billed within the month the member is referred if the member does not enroll in that month)
- *The outreach and engagement per member per month (PMPM) payment will be available for three (3) months. If outreach and engagement is unsuccessful (defined as neither locating nor engaging the child or family to enroll), the provider may continue outreach, but is not eligible to bill again for these activities until an interval of at least three months has elapsed since billing for outreach and engagement.*
- **Active and meaningful** outreach would include direct communications (face-to-face, electronic or by telephone), with the member (if appropriate, with appropriate consent) or their parent/guardian/legally authorized representative (with appropriate provisions to assure patient privacy is protected). There should be evidence that outreach efforts are progressive and are escalated as appropriate with the expected outcome of enrollment.
 - All outreach efforts **MUST** be documented in the members record

Outreach Communication

- If during outreach (prior to enrollment), the member (if appropriate) or the parent/guardian/legally authorized representative refuses Health Home services, then the Health Home Care Manager should contact the referent (the person who made the referral – information is included in the Health Home Referral Portal) and make them aware of such refusal of Health Home services and document such prior to closing the referral.
- ❖ *Remember: A minimum of verbal consent must be given by the member (if appropriate) or the parent/guardian/legally authorized representative for a HH referral to be made in the HH Referral Portal.*



Scenario 1:

Outreach and Billing

- If Joey is referred to a Health Home in February, the Health Home is providing active outreach but does not enroll the child in February, outreach (\$135) for the month of February may be billed
- If Joey is not enrolled in March but the Health Home continues to provide active and progressive outreach, outreach (\$135) may be billed for the month of March
- If Joey is enrolled on April 14th (appropriate consent signed), but does not receive a completed CANS-NY in the month of April, a low acuity PMPM may be billed

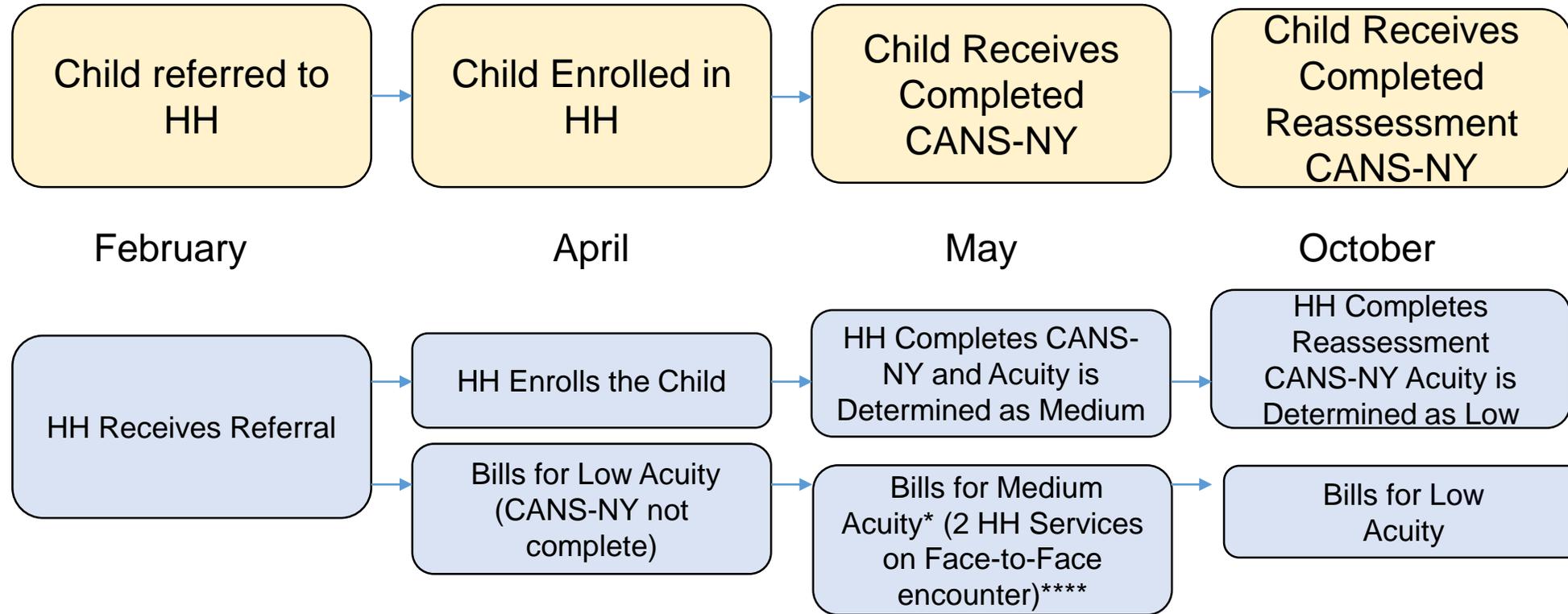
Scenario 2:

Outreach and Billing

- Joey is referred to a Health Home in February, active and progressive outreach is provided but Joey is not enrolled in the Health Home for February, March or April – Outreach (\$135) may be billed for each of those months
- The HH CMA may continue outreach in May, but is not eligible to bill again for outreach activities until an interval of at least three months has elapsed since billing for outreach and engagement.
- However, if the Health Home continues outreach for the month of May (with the intent to not bill for outreach) and enrolls the child in Health Home on May 17th, then the Health Home can bill low acuity for the month of May (assuming the CANS-NY has not also been completed in the month of May).



Tying it All Together



Health Home Eligibility

- It is the responsibility of the Care Manager to ensure that the child continues to meet Health Home eligibility and appropriateness criteria
 - Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
 - In addition, children meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes.
- **No less than quarterly**, care managers must actively **review** and **document** in the plan of care, the child's needs for Health Home Care Management services



Reviewing Health Home Appropriateness

Quarterly reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered Health Homes:

- The child no longer needs the intense level of care management services provided by the Health Home. Discharge planning will begin when one or more of the following exists:
 - ✓The chronic condition(s) that made the child eligible for Health Homes are being managed and or maintained,
 - ✓All parties concur the child has met the goals of his/her Plan and is stable enough to no longer require the services of a Health Home care management,
 - ✓Has service and support needs that can be met by family/guardian and services without the intensive level of HH care management
- The Care Manager can and should review if the child needs the intense level of care management provided by a Health Home regardless of the acuity used to determine HH PMPM rate (High, Medium, Low)
- The CANS-NY can assist with the development of the plan of care, however it does not determine when a child is discharged from a Health Home (e.g. a child with a CANS-NY medium acuity can be discharged)



Questions?



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- Stay up-to-date by signing up to receive Health Home e-mail updates
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http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm
- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action



Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



TRAINING



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Health Home Serving Children (HHSC) Training Schedule – JUNE and JULY 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	JUNE & JULY 2016
Information on the NYS Child Welfare System and Defining the Collaborative Roles for HH and CMAs	June 1 st
Complex Trauma draft proposal review to obtain stakeholder feedback	June 8 th
Information regarding OASAS Programs, Services and Addiction for HH and CMAs	June 15 th
CANS-NY - In person training - Albany School of Public Health Auditorium	June 22 nd & 23 rd
Health Home Serving Children Billing Guidance	June 29 th
CANS-NY - In person Training - NYC – 90 Church St	July 12 th & 13 th
MAPP Referral Portal	July 13 th
Care at Home (CAH) I & II	July 27 th



Health Home Serving Children (HHSC) Training Schedule – AUGUST 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	AUGUST 2016
Child Welfare interface with Health Home Serving Children - Roles and Responsibilities	August 10 th
Health Home Serving Children Consent Process	August 17 th
CANS-NY In person Training - Rochester Training - Hillside Family of Agencies	August 18 th & 19 th
Health Home Serving Children outreach, eligibility and appropriateness determination	August 24 th
CANS-NY - In person training - NYC – 90 Church St	August 29 th & 30 th
OMH TCM program transition	August 31 st



Health Home Serving Children (HHSC) Training Schedule – SEPTEMBER 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	SEPTEMBER 2016
Health Home Serving Children 101 for Early Intervention Providers	September 6 th
Early Intervention Services and System for HH and CMAs	September 7 th
MAPP training - MAPP HH User, HH CMA, MAPP for LDSS, LGU, SPOA, DOH and State partner users	Three weeks prior to go live TBD
Health Home Serving Children 101 for HIV and AIDS providers	September 20 th
Information and education from the AIDS Institute for HH and CMAs	September 21 st
UAS training environment and how to use the system	Available once user has HCS account provisioned roles
UAS 1300 - Using the UAS to conduct CANS assessments	TBD
UAS 1500 - Understanding the CANS assessment	TBD
UAS 1820 - CAPS and SCALES	TBD
UAS 1850 - CANS Assessment Outcomes	



APPENDIX



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Comprehensive Care Management

- **Examples of activities that constitute providing comprehensive care management under the Health Home model include:**
 - Completing a comprehensive assessment, inclusive of medical, behavioral, rehabilitative and long term care and social service needs.
 - Completing and revising, as needed, the child's person centered, family-focused, plan of care with the child and family to identify the child's needs and goals, and include family members and other social supports as appropriate.
 - Consulting with multidisciplinary team, primary care physician, and specialists on the child's needs and goals.
 - Consulting with primary care physician and/or specialists involved in the treatment plan.
 - Conducting clinic outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes.
 - Preparing crisis intervention plans.



Care Coordination and Health Promotion

- **Examples of activities that constitute providing Care Coordination and Health Promotion under the Health Home model include:**
 - Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information.
 - Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
 - Conduct case reviews with the child/family and interdisciplinary team to monitor/evaluate client status/service needs.
 - Crisis intervention – revise care plan/goals as required.
 - Advocate for services and assist with scheduling of services.
 - Monitor, support, and accompany the child and family to scheduled medical appointments.
 - Provide conflict free case management.



Comprehensive Transitional Care

- **Examples of activities that constitute providing Comprehensive Transitional Care include:**
 - Follow up with hospitals/ER upon notification of child's admission and/or discharge to/from an ER, hospital/ residential/rehabilitative setting.
 - Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
 - Link child/family with community supports to ensure that needed services are provided.
 - Follow up post discharge with child and family to ensure needed services are provided.
 - Notify and consult with treating clinicians, including child's primary care physician, schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., schools and day care), and assist with medication reconciliation.



Patient and Family Support

- **Examples of activities that constitute providing Patient and Family Support under the Health Home model include:**
 - Develop, review, revise child's plan of care with child and family to ensure plan reflects child/family's preferences, education, and support for self-management.
 - Consult with child/family/caretaker on advanced directives and educate on client rights and health care issues as needed.
 - Meet with child and family, inviting any other providers to facilitate needed interpretation services.
 - Refer child and family to peer supports, support groups, social services, entitlement programs as needed.



Referral to Community and Social Support Services

- **Examples of activities that constitute making referrals to Community and Social Support Services include:**
 - Identify resources and link child/family to community supports as needed
 - Collaborate and coordinate with community based providers to support effective utilization of services based on child/family need

Health Homes Serving Children

List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit



Health Homes Serving Children

List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS: Universal Assessment System
- VFCA: Voluntary Foster Care Agency

